1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11306

CERTIFICATE OF DEATH

11324

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY: Charles — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head

LENGTH OF STAY (in this place): 30yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 19 Indian Head Ave

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Md — COUNTY: Charles

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head

STREET ADDRESS (If rural give location): 19 Indian Head Ave

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Chiles (Last) Abell

4. DATE OF DEATH (Month) Oct. (Day) 27 (Year) 19 59

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 5, 1904	55 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Auto Sales

11. BIRTHPLACE (State or foreign country): Indian Head, Md.

12. CITIZEN OF WHAT COUNTRY? US.

13. FATHER'S NAME: Park Custis Abell

14. MOTHER'S MAIDEN NAME: Ora Ella Mitchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-32-5842

17. INFORMANT & ADDRESS: Mrs Wm. C. Abell, 19 Indian Head Ave, Indian Head, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE (A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr.

ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Heart Disease — 34yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to 10/27, 1959, that I last saw the deceased alive on 10/27, 1959, and that death occurred at 7:45 P M, from the causes and on the date stated above.

SIGNATURE: Frank A. Owsen, M.D. — ADDRESS (Street, city, town, state): Indian Head Md — DATE SIGNED: 10-27-59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-30-59	Park Hill	Marbury, Md.

24. REC'D BY REGISTRAR DATE: NOV 4 '59 — REGISTRAR'S SIGNATURE: Clement L. Mudd

25. FUNERAL DIRECTOR'S SIGNATURE: Arehart Funeral Home, Inc. — ADDRESS: La Plata, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11307

1. PLACE OF DEATH
a. COUNTY Charles 11325 MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First JOHN Middle HARRISON Last COOMBS
4. DATE OF DEATH Month OCTOBER Day 1 Year 1959
5. SEX M
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Mar 9, 1915
9. AGE (In years last birthday) 44 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) restaurant worker
10b. KIND OF BUSINESS OR INDUSTRY restaurant
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Joseph Coombs
14. MOTHER'S MAIDEN NAME Matilda Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Julia Johnson, Address La Plata Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bilateral Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 days
490X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Addiction to alcohol
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. none
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury
20c. TIME OF INJURY Month, Day, Year Hour a. m. no injury 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) LA PLATA (County) CHARLES (State) MD.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE V B Dettor M.D.
EXAMINER'S NAME (Type) V. B. DETTOR, M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED 10-3-59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-5-59
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem
22d. LOCATION (City, town, or county) La Plata (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hontt Funeral Home, Waldoy Md
24a. REC'D BY REGISTRAR DATE OCT 6 '59
24b. REGISTRAR'S SIGNATURE Arthur L Frame

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11326

CERTIFICATE OF DEATH

Reg. Dist. No. 11308

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - WALDORF
c. LENGTH OF STAY IN 1b: 8 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RT 1 BOX 58

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - WALDORF
d. STREET ADDRESS: RT 1 BOX 58
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: LLOYD — Middle: GEORGE — Last: DIXON, JR.

4. DATE OF DEATH: Month: Oct. — Day: 22 — Year: 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 1ST 1941

9. AGE (In years last birthday): 18 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): DISTRICT OF COLUMBIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LLOYD GEORGE DIXON

14. MOTHER'S MAIDEN NAME: DOROTHY MAY SMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: DOROTHY M. DIXON - MOTHER — Address: RT 1 BOX 53 WALDORF MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): TERMINAL BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 20 hrs

355 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): SPINO-CEREBELLAR ATAXIA — 4 YRS.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): UREMIA — 2 MOS.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): NONE

20c. TIME OF INJURY: Hour o. r. p. m. — Month, Day, Year: NONE 19

20d. INJURY OCCURRED: While at work ☑ Not while at work ☐ NONE

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): NONE

20f. (City or town) (County) (State): NONE

21. I certify that I attended the deceased from OCT., 1957, to PRESENT, that I last saw the deceased alive on Oct 22, 1959, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur Shaver Jr. M.D. — ADDRESS (Street, city or town, state): Branch Ave. - Clinton, Md. — DATE SIGNED: 10/23/59

PHYSICIAN'S NAME (Type): ARTHUR SHAVER JR. M.D. BRANCH AVE. - CLINTON, MD. 10/23/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Oct 26-59 — 22c. NAME OF CEMETERY OR CREMATORY: Adar Hill — 22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros. — ADDRESS: 1661-gd Hope Rd & E

24a. REC'D BY REGISTRAR DATE: OCT 26 '59

24b. REGISTRAR'S SIGNATURE: Clifton L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11327 — Reg. Dist. No. 11309

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaPlata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Arehart Funeral Home, Inc.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: 414 Westgrove Blod
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First GORDON — Middle O. — Last JOHNSON

4. DATE OF DEATH: Month October — Day 18, — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 6, 1909

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Manager, Supt.

10b. KIND OF BUSINESS OR INDUSTRY: Gosnell & Inc.

11. BIRTHPLACE (State or foreign country): North Dakota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Johnson

14. MOTHER'S MAIDEN NAME: Lynn Paulson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 578-40-2347

17. INFORMANT — Address: J.E. Johnson, 14E. Reed Ave, Alexandria, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell off boat

20c. TIME OF INJURY — Hour a. m. — Month, Day, Year: 10/18/1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): River

20f. (City or town): LaPlata — (County): Charles — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.F. Fisher M.D. — CHIEF MEDICAL EXAMINER ☒ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☐ — DATE SIGNED: 10/19/59

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-21-1959
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Fort Myer, Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE: A.L. Rowe — ADDRESS: # 333 Alexandria Va.

24a. REC'D BY REGISTRAR — DATE: OCT 21 '59

24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11311

CERTIFICATE OF DEATH

11328 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Indian Head
d. STREET ADDRESS: 21 Kenwood Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Carroll Last McWilliams
4. DATE OF DEATH: Month Oct Day 22 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 6, 1890
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Naval Propellant Plant
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emmanuel McWilliams
14. MOTHER'S MAIDEN NAME: Parnell E.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mrs. John C. McWilliams, Indian Head, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Thrombosis	6 hrs.
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Arteriosclerotic Heart Disease	10 yrs.
DUE TO (c)		

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1949 to Oct 22, 1959, that I last saw the deceased alive on Oct 22, 1959, and that death occurred at 12:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank G. Susan M.D. ADDRESS (Street, city or town, state): 5 Indian Head Ave DATE SIGNED: 10/23/59
PHYSICIAN'S NAME (Type): Frank A. Susan M.D. Indian Head, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-24-59
22c. NAME OF CEMETERY OR CREMATORY: St Marys
22d. LOCATION (City, town, or county) (State): Piscataway, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The Hunter Funeral Home ADDRESS: Waldorf, Md.
24a. REC'D BY REGISTRAR DATE: OCT 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11329

11312

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY Charles MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf
c LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Md b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf (RURAL)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First MARY Middle MARTIN Last MIDDLETON

4 DATE OF DEATH Month 10 Day 23 Year 1959

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 3-15-70

9 AGE (In years last birthday) 89 yrs

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY at Home.

11. BIRTHPLACE (State or foreign country) Pomfret Charles Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ? Martin

14. MOTHER'S MAIDEN NAME MARY ROBEY

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO NOT KNOWN

INFORMANT MRS TOM MIDDLETON Address WALDORF MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 10-22-59

DUE TO (b) Hypertension 1949

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 1949, to 10-22-59, that I last saw the deceased alive on 10-21-59, and that death occurred at 8:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE E. J. Edelen M.D. ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 10-25-59

PHYSICIAN'S NAME (Type) E. J. EDELEN M.D. LA PLATA, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 10-26-59 22c. NAME OF CEMETERY OR CREMATORY St. Peters 22d. LOCATION (City, town, or county) Waldorf (State) Md

23 FUNERAL DIRECTOR'S SIGNATURE Middleton Funeral Service ADDRESS Waldorf Md

24a. REC'D BY REGISTRAR DATE OCT 28 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Frama

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS 11S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11330 **CERTIFICATE OF DEATH** Reg. Dist. No. 11313

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b: hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians' Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Faulkner
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Clyde — Middle Allen — Last Putnam

4. DATE OF DEATH: Month Oct. — Day 28 — Year 1959

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-19-1892

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Bridgework

11. BIRTHPLACE (State or foreign country): Louisiana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Edward Putnam

14. MOTHER'S MAIDEN NAME: Margaret Susan Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 261-09-3690

17. INFORMANT — Address: Mrs. Clyde A. Putnam, Faulkner, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs.

4 min.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized Arterio Sclerosis — 1957

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1956 to Oct. 28 1959 that I last saw the deceased alive on Oct. 28 1959, and that death occurred at 2 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. J. Edelen M.D.

ADDRESS (Street, city or town, state): La Plata, Maryland — DATE SIGNED: 10-29-59

PHYSICIAN'S NAME (Type): E. J. Edelen, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-31-59

22c. NAME OF CEMETERY OR CREMATORY: Dentsville Methodist

22d. LOCATION (City, town, or county) (State): Dentsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The Huntt Funeral Home, Waldorf, Maryland

24a. REC'D BY REGISTRAR DATE: NOV 3 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11331

11314

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and [illegible] should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Charles
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Charles

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head
c. LENGTH OF STAY IN 1b: 26 yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1201 E Raymond St.

d. STREET ADDRESS: 1201 E Raymond St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James Middle: Daniel Last: Speake

4. DATE OF DEATH: Month: Oct. Day: 26 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb 28, 1905

9. AGE (In years last birthday): 54 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Navy Propellant Plant

11. BIRTHPLACE (State or foreign country): Chicamuxen, Md.

12. CITIZEN OF WHAT COUNTRY? U S.

13. FATHER'S NAME: James Lee Speake

14. MOTHER'S MAIDEN NAME: Beulah Groves

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-38-1831

17. INFORMANT: Mrs Jas D Speake
Address: 1201 E Raymond St. Indian Head, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immed.

420.1

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Heart Disease — 5 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: o. m / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1957 to Oct 1959 that I last saw the deceased alive on Oct 15 1959, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank A. Susan M.D.
ADDRESS (Street, city or town, state): 5 Indian Head Ave
DATE SIGNED

PHYSICIAN'S NAME (Type): Frank A Susan M.D.
Indian Head, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried

22b. DATE THEREOF: 10/28/59

22c. NAME OF CEMETERY OR CREMATORY: Chicamuxen Cemetery

22d LOCATION (City, town, or county) (State): Chicamuxen Md

23. FUNERAL DIRECTOR'S SIGNATURE: Hewitt Funeral Home
ADDRESS: Waldorf Md

24a. REC'D BY REGISTRAR DATE: OCT 30 '59

24b. REGISTRAR'S SIGNATURE: Chas S Tawes

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 rit- TJ 10-27-59 et

11332

CERTIFICATE OF DEATH

11315

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata
c. LENGTH OF STAY IN 1b 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Doncaster
d. STREET ADDRESS Rural
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First JAMES Middle H Last THOMPSON
4. DATE OF DEATH Month OCTOBER Day 13 Year 1959
5. SEX MALE
6. COLOR OR RACE NEGRO
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 2-2-1877
9. AGE (In years last birthday) 82 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Thompson
14. MOTHER'S MAIDEN NAME Margaret Hicks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Maurice J. Lucas — 102-N. 2d. S.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH 2 wks.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Benign Prostatic Obstruction — 4 years
DUE TO (c) Chronic arteriosclerotic Renal Disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) No injury
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. No injury
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) No injury
20f. (City or town) (County) (State) No injury

21. I certify that I attended the deceased from 10-2, 1959 to 10-13, 1959 that I last saw the deceased alive on 10-13, 1959, and that death occurred at 11:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE V B Dettor M.D. ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 10-14-59
PHYSICIAN'S NAME (Type) V.B. DETTOR M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 10-19-59
22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Church Cemetery
22d. LOCATION (City, town, or county) (State) Charles County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Montgomery Bros. ADDRESS 913-7th St. N.W.
24a. REC'D BY REGISTRAR DATE OCT 21 '59
24b. REGISTRAR'S SIGNATURE Arthur L Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11335 — Reg. Dist. No. 11316

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b: 1 week

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Virginia — b. COUNTY: Westmoreland
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colonial Beach
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): X

3. NAME OF DECEASED (Type or print): First: Roy — Middle: (N.M.N.) — Last: Tyler
4. DATE OF DEATH: Month: 10 — Day: 15 — Year: 1959
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 29 1910
9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saw Mill & Farming
10b. KIND OF BUSINESS OR INDUSTRY: Saw Mill
11. BIRTHPLACE (State or foreign country): Columbia Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willie J. Tyler
14. MOTHER'S MAIDEN NAME: Lillie Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Nil.
17. INFORMANT: Address: Mr. Jack C. Tyler — Colonial Beach Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10-15-59
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Logging when he collapsed
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E J Edelen M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☑ — DATE SIGNED: 10-15-59
EXAMINER'S NAME (Type): E. J. EDELEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/18/59
22c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove
22d. LOCATION (City, town, or county) (State): Columbia, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Thomason Funeral Home, Va
ADDRESS: Louisa
Orchard Funeral Home, Colo

24a. REC'D BY REGISTRAR DATE: OCT 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11334 — 11317 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt Victoria
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mt Victoria
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JAMES Middle CHESTER Last WASHINGTON
4. DATE OF DEATH: Month OCT. Day 6 Year 1959
5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 3-13-55
9. AGE (In years last birthday): 4 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Chester Edward Washington
14. MOTHER'S MAIDEN NAME: Nellie Ann Brown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Louise Brown, Address: Mt Victoria, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gasoline poisoning — INTERVAL BETWEEN ONSET AND DEATH: 1h. 15m.
E880.0
DUE TO (b): Ingestion of Gasoline
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Drank from a can -
20c. TIME OF INJURY: Hour 5 p. m. Month, Day, Year 10-6 1959
20d. INJURY OCCURRED While at work [ ] Not while at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) MT. VICTORIA, (County) CHARLES, (State) MD.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X] and find that death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: V B Detter M.D.
EXAMINER'S NAME (Type): V. B. DETTOR M.D.
CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 10-6-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-8-59
22c. NAME OF CEMETERY OR CREMATORY: Holy Ghost
22d. LOCATION (City, town, or county) (State): Issue, Md.
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: The Hurd Funeral Home, Waldorf, Md.
24a. REC'D BY REGISTRAR DATE: OCT 9 '59
24b. REGISTRAR'S SIGNATURE: Clarence E. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11335 Item 2 Film G250 10-19-59 et

11318

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN 1b: NONE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PHYSICIAN'S MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DIST. OF COL. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON DC. 47X-3
d. STREET ADDRESS: No fixed address Prior to Admiss. U.S. SOLDIERS HOME
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle J — Last WELCH
4. DATE OF DEATH: Month OCTOBER — Day 12 — Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/9/1881
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. ARMY
10b. KIND OF BUSINESS OR INDUSTRY: MILITARY
11. BIRTHPLACE (State or foreign country): PORTLAND, ME
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) If yes, specify war or dates of service: YES PI, + WWI
16. SOCIAL SECURITY NO.: 538-16-4266
17. INFORMANT: Records — Address: U.S. Soldiers' Home, WASH 25, D-C

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None known
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH: none
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Collapsed from chair in restaurant
20c. TIME OF INJURY: Hour 12:20 P.M. — Month, Day, Year 10-12-1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☑
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Restaurant
20f. (City or town) WALDORF, (County) CHARLES, (State) MD.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: V B Dettor M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☑ — DATE SIGNED: 10-12-59
EXAMINER'S NAME (Type): V. B. DETTOR M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 10/14/59
22c. NAME OF CEMETERY OR CREMATORY: U.S. SOLDIERS HOME NATL.
22d. LOCATION (City, town, or county) WASH 25 (State) DC

23. FUNERAL DIRECTOR'S SIGNATURE: Stanley Jones — ADDRESS: Soldiers Home
24a. REC'D BY REGISTRAR DATE: OCT 14 '59
24b. REGISTRAR'S SIGNATURE: Clifton A. Rivers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55